PEDIATRICS
IN BREVARD

18+ Years Registration Form

Today's Date: _____

Patient's Name _____

Date of Birth _____ Sex ☐ M ☐ F

Patient's Address _____

_____
City State Zip

Phone # Patient's Home _____ Patient's Cell _____

Patient's E-Mail address _____

Race (*check one*)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian ☐ Other Pacific Island ☐ White ☐ Declines to respond

Preferred Language ☐ English ☐ Spanish ☐ Other (specify)_____

Ethnicity (*check one*) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declines to Respond

Vision or Hearing Barriers to Communication? ☐ Yes ☐ No

If yes, please specify_____

Emergency Contacts

Name_____ Relation to patient: _____ Phone # (home, work, cell)_____

Name_____ Relation to patient: _____ Phone # (home, work, cell)_____

Name_____ Relation to patient: _____ Phone # (home, work, cell)_____

(See Reverse Side)

Insurance Information

(Pediatrics in Brevard does ***not*** file secondary insurance. This included Medicaid and Medicaid Managed Care/MMA Plans. You will be responsible for all copays, deductibles, coinsurance, etc., that apply to your primary insurance, at the time of service.)

Insurance Company_____ **ID#**_____ **Group#**_____

Policy Holder's Name_____ **Relationship to Patient**_____

Policy Holder's DOB_____ **Policy Holders SS#**_____

By signing this section I authorize the submission of claims to the insurance company above and understand that in order to submit insurance under a subscriber, other than myself, that subscriber (***OFTEN YOUR PARENT***) will have access to medical information needed by the insurance company to process claims. Medical information may include, but is not limited to, mental health, substance abuse, birth control, pregnancy, STD, etc. The insurance company could release information to the subscriber according to arrangements between the insurance company and the subscriber. I understand that this may occur without my prior knowledge or consent. I understand that Pediatrics in Brevard is not responsible for any information that the insurance company releases to the subscriber.

Signature of Patient: _____ **Date**_____

By signing this section ***I do NOT authorize claim submissions to my insurance*** for DOS_____.
I agree that the payment of the visit will be my responsibility and payment is due in full on the date services are rendered.

Signature of Patient: _____ **Date**_____

Authorization of Treatment and Insurance/Financial Agreement

I acknowledge that I have received a copy of the Pediatrics in Brevard Notice of Privacy Practices for review. I understand that if I have any questions about the Notice of Privacy Practices I may contact the Privacy Officer at (321) 636-3066, or discuss any questions I may have with my provider.

I authorize providers of Pediatrics in Brevard to treat, prescribe medications, obtain prescription history, etc. for myself as the providers feel necessary.

I authorize my insurance benefits to be paid directly to Pediatrics in Brevard. I authorize the release of pertinent medical information, including motor vehicle, disability or employment related information concerning claims to my insurance carriers, authorized agents(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses.

I agree that in consideration for the services to be provided by Pediatrics in Brevard, I'm responsible for payment of all services and account charges/fees, including copayment, co-insurance, deductible, non-covered services and those due to false information.

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

Print Name: _____